HOUSE OF COMMONS SESSION 1998–99

HEALTH COMMITTEE

Third Report

FUTURE NHS STAFFING REQUIREMENTS

Volume I

Report and Proceedings of the Committee

Ordered by The House of Commons *to be printed*
11 February 1999

LONDON: THE STATIONERY OFFICE
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38–I

The Health Committee is appointed under Standing Order No. 152 to examine the expenditure, administration and policy of the Department of Health and associated public bodies.

The Committee consists of 11 Members. It has a quorum of three. Unless the House otherwise orders, all Members nominated to a committee appointed under this order shall continue to be members of that committee for the remainder of the Parliament.

The Committee has power;

1. to send for persons, papers and records, to sit notwithstanding any adjournment of the House, to adjourn from place to place, and to report from time to time;

2. to appoint specialist advisers either to supply information which is not readily available or to elucidate matters of complexity within the Committee's order of reference;

3. to communicate to any other committee appointed under the same Standing Order (and to the European Scrutiny Committee, to the Committee of Public Accounts, to the Deregulation Committee and to the Environmental Audit Committee) its evidence and any other documents relating to matters of common interest; and

4. to meet concurrently with any other such committee or with the European Scrutiny Committee or any sub–committee thereof for the purposes of deliberating, taking evidence, or (in the case of any other such committee), considering draft reports.

The membership of the Committee since its nomination on 14 July 1997 has been as follows:

Mr David Amess (*added 20 July 1998)*
Mr John Austin
Dr Peter Brand
Mr Peter Brooke (*discharged 21 July 1997)*
Julia Drown
Mr John Gunnell
Mr David Hinchliffe
Ann Keen *(discharged 1February 1999)*
Mr Andrew Lansley (*discharged 20 July 1998)*
Mr Ivan Lewis *(added 1 February 1999)*
Dr Howard Stoate
Mr Robert Syms
Mr Robert Walter *(added 21 July 1997)*
Audrey Wise

Mr David Hinchliffe was elected Chairman on 17 July 1997.

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The following memoranda have been reported to the House, but to save printing costs they have not been printed and copies have been placed in the House of Commons Library, where they may be inspected by Members. Other copies are in the Record Office, House of Lords, and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London, SW1 (tel 0171 219 3074). Hours of inspection are from 9.30 am to 5.00 pm on Mondays to Fridays.

Memoranda or supplementary memoranda submitted by:

Department of Health (NHS Executive) [SR 1]

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Community and District Nursing Association [SR 5A]

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THIRD REPORT

The Health Committee has agreed to the following Report:—

FUTURE NHS STAFFING REQUIREMENTS

Introduction

1. The NHS is in the midst of a staffing crisis. One academic has described nursing shortages[1] as being of a cyclical nature, but this particular shortage appears to be much worse than those of the past. Most groups of staff are in short supply.

2. In 1997 and 1998 the Department of Health (DoH) introduced a number of policy initiatives and proposals intended to modernise the NHS, improve standards for patients and tackle perceived staffing difficulties.[2] Following the 1998 Comprehensive Spending Review the NHS in England was allocated an extra £18 billion over the ensuing three years. This figure included £50 million devoted to tackling nursing shortages in the NHS. The written evidence we received described serious staffing problems faced by the NHS, but gave broad support to the Government's approach to dealing with them.

3. The Government's plans for the NHS are ambitious and comprehensive. But we felt it important, particularly in the light of current serious staff shortages and the factors underlying them, to test the robustness of the staffing projections underpinning the proposed reforms. UNISON suggested that whilst the Government intended to create 15,000 more posts and 6-7,000 more training places for nurses, and to increase the annual intake of medical students by 1,000 these measures would not alleviate understaffing since they would be:

> "Largely consumed by the expansion in NHS services also announced in the [Comprehensive Spending] Review, and will take some time to feed through."[3]

4. There is also a worrying uncertainty surrounding the ability of the NHS to recruit the increased numbers of nurses and trainee nurses currently proposed by the Government. The Director of Human Resources at the National Health Service Executive (NHSE): felt that, the recruitment of more doctors would be relatively straightforward, but increasing the overall number of nurses in the NHS by up to 15,000 over three years represented a "substantial task".[4]

5. We decided to undertake this inquiry with a view to testing the staffing assumptions being made, assessing recruitment and retention strategies and where necessary making recommendations designed to help the Government to fulfill its intentions.

6. During the course of our investigation we received over 100 memoranda. These attributed staffing problems in the NHS to poor conditions of service, poor career structures, low morale, low status, heavy workloads, a lack of employment security, stress, bad management, the absence of flexible, family-friendly working conditions, violence and harassment and - most insistently - inadequate pay. In a memorandum to us a nurse explained why, after 19 years service, she was leaving the NHS. She cited "all the changes", "harder work loads", "more demanding patients and employers", and "of course poor pay" as her main reasons for going and concluded:

> "I will be sad to leave but feel that for my future financial and professional well being the NHS is not a healthy place to be."[5]

7. Our programme of oral evidence included contributions from DoH officials, the Chairman of the Medical Workforce Standing Advisory Committee, staff representative groups, the NHS Confederation, representatives of local education consortia, and the Secretary of State for Health. A list of all those who gave written and oral evidence is on pages iv to x.

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[1] *Your Country Needs You* by James Buchan, Health Service Journal, 16 July 1998.
[2] The Green Paper, *Our Healthier Nation*; The NHS White Paper, *The New NHS*; *A First Class Service - Quality in the new NHS*; The new Human Resources Framework, *Working Together - Securing a quality workforce for the NHS.*
[3] Ev. p104, para 32.
[4] Q50.
[5] Appendix 5.

8. We felt it was important to speak face to face with NHS personnel in order to establish the opinions of workers at grass-root level. We visited Darlington, Birmingham and the Royal London Hospital where we were able to listen to the views of a wide cross-section of staff. We also met informally a group of junior doctors from around the country. These were informative and revealing exercises. We are grateful to all those who participated.

9. To support our work we appointed three Specialist Advisers. We wish to place on record our thanks to Dr Graham Buckley, Executive Director, Scottish Council for Post Graduate Medical and Dental Education, Lois Crooke, Director, Wolfson Institute of Health Sciences, Thames Valley University and Patricia Oakley, Director, Practices Made Perfect Ltd, for their invaluable help.

10. We wanted our investigation to be wide-ranging and inclusive. We have talked directly to, or with representatives of, most categories of staff working within the NHS. At the start of the inquiry we recognised that the issue of NHS dentists was distinct and would require a separate study. We note from the DoH memorandum that:

> "The Department of Health is proposing to undertake a literature review on dental manpower issues and will be undertaking a dental career intentions review. These reviews will inform the basis for submitting recommendations on the dental workforce for the future."[6]

We await the outcome of these reviews with interest.

The Government's Plans

11. The Government has committed itself to reforming the NHS. Developments in primary care, notably the creation of Primary Care Groups (PCGs), Health Improvement Programmes (HimPs), Health Action Zones, NHS Direct, National Service Frameworks and Clinical Governance will have a considerable impact on the role of staff and the numbers involved; so too will the pressure to reduce waiting lists.

12. The implications for the NHS of the New Deal for junior doctors and the EU Working Time Directive[7] will also have to be properly monitored and accurately assessed. MSF told us that the impact of the Working Time Directive on laboratory staff could "make the difference in some places between the Service working properly and it seriously not working properly".[8] The British Medical Association (BMA) estimated that 4,000 extra consultants would be needed to implement the Calman changes (which improved training programmes for junior doctors and created a unified training grade) and New Deal reforms, aimed at reducing the hours worked by junior doctors. This expansion in consultants has not occurred so far. The BMA also argued that the Working Time Directive and general social change would render long working hours "increasing unacceptable".[9] Mr Nigel Turner of the NHS Confederation believed that there was need for forward planning to overcome the impact of a reduction in junior doctors' hours.[10] Some nursing staff we met spoke of the extra work, and consequent additional pressure, that devolved to them as a result of the change in junior doctors' hours. This same point was made in respect of the professions allied to medicine (see paragraph 87 below). It was also suggested to us that shortage of nurses could impact on the tasks performed by junior doctors.

13. Details of the Government's plans can be found in the policy documents and consultation papers already listed; a summary of the Government's objectives is included in the memorandum from DoH.[11] We accept that the Government has shown itself to be aware of the problems facing

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[6] Ev. p17, Annex D, para 7.
[7] The *Working Time Regulations 1998 SI No 1833,* were laid before Parliament on 30 July 1998. They came into force on 1 October 1998.
[8] Q200.
[9] Ev. p155.
[10] Q236.
[11] Ev. p10.

the NHS and has indicated its intention to overcome them. All the areas of concern to staff outlined in paragraph 6 above are familiar to Government and we acknowledge the DoH's desire to bring about substantial improvements. We recognise that many of the staffing problems currently besetting the NHS are long-standing; it is partly because of the failure of successive Governments to tackle them that they have now become serious to the extent that the quality of healthcare provision is at risk.

14. Staff representative groups were generally supportive of the Government's approach. Mr Bob Abberley of UNISON said:

> "The Government I think, in the whole range of areas - new pay system, new human resource management strategy, looking at staff involvement, looking at family-friendly policies - is saying almost all the right things."

He added the caveat that it would not be easy to implement such "good intentions" in the hospital ward.[12]

15. We too generally welcome the Government's policy goals for the NHS in relation to staffing. But we believe that these policies may be undermined by the Government underestimating the number of staff needed to achieve its targets. The NHS Confederation argued:

> "Policies like the implementation of Calman for junior doctors, or the implications of Health Improvement Programmes of greater emphasis on mental health, cancer and heart patients have not been translated into the need for specialist resources."[13]

This point was reiterated during oral evidence.[14]

16. The Director of Human Resources at the NHS Executive (NHSE) frankly accepted that a problem existed with current staff calculations when he told us:

> "We need a stronger alignment in practice between policy development...and assessing the workforce implications of it...It is very easy and tempting...to develop policies which for all the best reasons are social priorities or whatever without necessarily thinking through all the workforce implications of them. That is something which we recognise we need to do better."[15]

The NHS Team

17. The NHS has always been able to rely on the loyalty and commitment of its staff. As the Director of Human Resources at NHSE noted:

> "We still retain huge staff loyalty. There is a very strong adherence to the values of NHS and what it stands for, which is a huge asset for us."[16]

Representatives of MSF and UNISON both listed reasons why people had once wanted to work for the NHS. These included job satisfaction, security of employment, responsibility for decision making and a feeling of being valued.[17] They saw these features as being undermined. During our visit to the Royal London Hospital, hospital consultants enthusiastically endorsed the importance of team work. They argued that all staff were at the front line of patient care, a sentiment we endorse. It was suggested that such esprit de corps was being eroded by declining staff loyalty to

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[12] Q177. See further the comments of the Royal College of Nurses (RCN) and Royal College of Midwives (RCM) at Q145; and those of Professions Allied to Medicines (PAMS) at Q111; see also, for example, the article by James Buchan, *Your Country Needs You* in Health Service Journal, 16 July 1998, which links the present nursing shortage to the reduction in the number of nurses in training in the early 1990s.
[13] Ev. p162, para 2.10.
[14] Q224.
[15] Q56.
[16] Q7.
[17] Qq142 and 143.

the NHS and the Service's reduced commitment to staff, trends which would be difficult to reverse. The move from consensus[18] to general management in the early 1980s, the advent of trusts and the internal market, the over-use – indeed abuse – of agency and bank nurses and the attendant lack of continuity of care is felt by those who have given evidence to us to have created a climate not conducive to overall organisational cohesion.

18. We regret the dilution of the collective ideal in the NHS. The Government's intention to increase co-operation and share best practice should prove a welcome step towards reversing this trend, along with its efforts to improve the management culture in the NHS. But we believe that much more needs to be done. In particular we feel that the Government's continued support for the Private Finance Initiative (PFI) as it currently affects the Health Service might further diminish staff morale. We will discuss the impact of the PFI more fully later in the report.

Workforce Planning

19. Workforce planning in the NHS is notoriously problematic. The Government acknowledged this in its memorandum:

> "Successive governments have tried to achieve better planning of the workforce....Workforce planning is not an exact science, and is subject to complex variables...there are information gaps...The timescales are challenging... approaches to healthcare are changing and it is difficult to forecast with accuracy the long-term implications of skill mix and productivity changes, shifts in clinical care, technological advances or changes in patterns of disease."[19]

20. The Director of Human Resources at NHSE reminded us of the gap between the introduction of changes in the workplace and their inclusion in workforce planning mechanisms:

> "changes that are happening in the Service are moving ahead of the formal workforce planning mechanisms that we have.....There is always ...bound to be some sort of gap between innovation and development on the ground and the extent to which that is captured effectively within formal workforce machinery."[20]

Workforce calculations are further complicated by the long training periods required and the need to take account of drop out rates and retirement.

Workforce Planning Mechanisms

21. There are a number of bodies which contribute to the overall NHS workforce planning process. On the medical side there is the Advisory Group in Medical and Dental Education, Training and Staffing (AGMETS), the Medical Workforce Standing Advisory Committee (MWSAC), the Specialty Workforce Advisory Group (SWAG), the Medical Practices Committee (MPC), and Local Medical Workforce Advisory Groups (LMWAGs). The function of these groups is described in the DoH memorandum.[21]

22. Workforce planning for non-medical groups is employer-led through education consortia which bring together representatives of health authorities, trusts, GPs, social services and the independent sector to estimate their workforce planning needs and to plan the necessary education and training. The efforts of consortia are distilled through Regional Education and Development Groups (REDGs) who advise NHSE regional offices on the acceptability and coherence of consortia workforce plans and on the strategic direction of education and development.

23. A sub-group of the NHS Executive provides a national overview, advises on education and

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[18] Consensus management was a triumvirate of views between the administration, the head of the medical divisions, and the head of nursing. It was abandoned in 1983 following the Griffiths' reorganisation and replaced by general management.

[19] Ev. pp 9 and 10, para 5.1.

[20] Q12.

[21] Ev. p34, Annex D.

workforce issues and makes recommendations about necessary changes and their implementation.

24. The present planning arrangements have been subject to some criticism. The NHS Confederation acknowledged that there needed to be "integration between medical and non-medical workforce planning and the other aspects of [the] system that do not work so effectively should be reviewed."[22] It believed that:

> "systems for identifying future requirements do not currently look across all healthcare professions, but work in a fragmented manner"[23] and that "workforce planning would be improved by streamlining the current complexity of mechanisms and systems, in particular integrating medical and non-medical healthcare professionals within healthcare workforce planning against current and future service delivery needs."[24]

25. The King's Fund recognised the need for increased staff flexibility in terms of the roles performed, but identified obstacles to such a development. It believed that growth in clinical care and increased specialisation reduced flexibility by creating the need for additional training whilst making it difficult, if not impossible to switch specialties in mid-career.[25] The King's Fund also drew attention to the impact of professional barriers which, it argued, inhibited progress towards a more integrated approach to planning.

> "Flexibility is further reduced by deep-seated institutional factors within the NHS workforce, particularly its division into different professions, between which there is very little movement. Furthermore the Service has largely worked with the specific 'skill bundles' that have emerged from the professions themselves and these in turn have not been devised with flexibility in mind nor indeed with the needs of the Service. As a result, roles and training programmes cutting across existing professional boundaries have proved very hard to develop."[26]

26. Mr Bob Abberley, Head of Health at UNISON told the Committee that:

> "workforce planning needs to be across the workforce as a whole, and involving all organisations delivering care ...The problem is the NHS is compartmentalised...[27] we have to have a training and qualification system which allows people to move up through from virtually the cleaner to the doctor."[28]

27. Miss Christine Hancock, General Secretary of the RCN considered that the Government had not got the figures right:

> "because I do not think they know where they come from, and workforce information, workforce planning...is incredibly poor in the Health Service."[29]

Mr Roger Kline of MSF suggested that:

> "if you do not employ [staff] in the right numbers and with the right training, it actually costs the Health Service lots and lots of money."[30]

28. The Royal College of General Practitioners believed that LMWAGs and consortia were taking time to work together with health authorities and Trusts[31] and the RCN thought that greater dialogue was needed between consortia and universities. Education consortia are still relatively

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[22] Ev. p161.
[23] Ibid, para 2.7.
[24] Ibid, para 6.3.
[25] Appendix 68.
[26] Ibid. See also Ev. p108, para 66; Q118; Ev. p74 ; Appendix 67, para 6.5
[27] Q127.
[28] Q129.
[29] Q123.
[30] Q214.
[31] Appendix 15.

young and with the spread of good practice we believe they can be expected to develop and improve. It will be their task to ensure that they are representative of all the staff who come within their remit.

29. Another problem with the current workforce planning system was put to us by the British Psychological Society who said that :

> " The recent devolution of workforce planning to local education and training consortia gives rise to anxieties about a loss of national perspective and strategic direction."[32]

30. This was a concern shared by clinical scientists who, for workforce planning purposes, currently fall under the auspices of education consortia. They argued that because of the numbers involved manpower planning for them should be carried out centrally and devolution to consortia would be ineffective.[33] In its memorandum DoH explained that it had introduced:

> "New arrangements to develop a strategic overview for smaller sections of [the] workforce with their specific problems and characteristics"[34]

The point was underlined by the Head of Workforce Planning and Education at NHSE :

> "There are some very small groups which benefit from national workforce planning...We have set up an advisory group for scientists and technicians which is going to commission a major workforce planning and recruitment retention survey, and take that forward during the next year."[35]

31. We welcome the establishment of this body, the National Advisory Group for Scientists and Technicians (NAGST). Its work should go a long way towards overcoming some of the fears of clinical scientists and others that they were not being properly considered in the planning process. At the moment membership of NAGST is confined to representatives nominated by NHS regional offices. Both the Conference of Clinical Scientists' Organisations[36] and the Council of Science and Technology Institutes, Health Care Scientific Advisory Committee[37] told us that stronger formal links are required between NAGST and national professional bodies. **We recommend that the Government takes steps to introduce such links.**

32. Whilst we heard oral evidence from the Chairman of MWSAC and from representatives of local education consortia, we did not undertake a systematic study of the whole range of workforce planning mechanisms. We accept the premise that there should be national policies that are delivered locally and monitored externally. Nevertheless we have come to the conclusion that workforce planning process is overcrowded with contributing forces and current arrangements would benefit from some streamlining. Mr Andrew Foster, Chairman of the NHS Human Resources Committee of the NHS Confederation said:

> "The system does not hang together. It is not integrated between medical workforce and non-medical workforce planning. Private care is not properly integrated into it; primary care is not; taking into account service planning is not. The way that the consortia can produce a workforce plan and then people cannot be recruited into training is not addressed."[38]

A related point concerning community children's nurse education was provided during our predecessor Committee's inquiry into *Health Services for Children and Young People in the*

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[32] Appendix 51.
[33] See, for example, Appendix 16 and Appendix 63.
[34] Ev. p9, para 5.3.
[35] Q25.
[36] Appendix 16, para 6(d).
[37] Appendix 63, para 4.2.1.
[38] Q227.

Community: Home and School.[39]

33. Mr Foster also believed that the system "has evolved as a set of parts rather than as a whole."[40] One of the effects of this development process is the lack of consistency between the various 'parts'. Mr Nigel Turner of the NHS Confederation commented:

> "Different assumptions are used in different consortia and potentially interpreted in different ways by the different institutions within these consortia."[41]

34. A concerted effort towards the development of an integrated planning body allowing for significant areas of appropriate joint training clearly needs to be made. Methods of introducing changes in approach and technological developments swiftly into the planning mechanisms must also be devised. This might not be easy to bring about in the short term. But a start should be made. At the very least **we consider that with immediate effect there should be improved interaction between the medical and non- medical planning bodies.**

35. The DoH memorandum informed us that:

> "Education consortia, REDGs and LMWAGs liaise closely...this is reinforced by cross-membership between the various groups."[42]

We believe that this should extend to regular meetings between MWSAC and REDGs, who should exchange information, discuss new ideas and develop plans. In an environment of rapidly changing technology and working practices this would seem to be a vital step.

36. In the longer term **we recommend a major review of current planning procedures which should pay particular regard to their rationalisation and eventual replacement by an integrated planning system. We think it necessary that any new system should not only incorporate the national overview currently provided by the sub-group of the NHSE, but also actively promote a national strategy for workforce planning which, allowing for local conditions, brings a sense of consistency and cohesion at present notable for its absence.**

37. The budgets for local education consortia come in two parts. There is a core budget used for basic and first registration training and a development budget for post-registration and financing new types of training.[43] Some education consortia have used the latter in an enlightened way. The Chair of the Inner London Education Consortia explained:

> "there are now different types of training, training in teams, training in new roles, training in dual roles, that we can now develop and speak to education providers about what we want and how they can design education courses which meet our needs."[44]

The Chair of the South Essex Education Consortia made the same point.[45]

38. **The issue of the provision of appropriate joint training throughout the UK should feature largely in the major review of current planning procedures that we have recommended.**

39. We also believe that there would be considerable benefit in a close study of how doctors are currently trained. The Chairman of MWSAC advocated courses for science graduates that would

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[39] Third Report (HC 314, Session 1996-97). We noted that: "Although the English National Board had approved institutions for community children's nurse education, most of the places could not be taken up because education consortia had not commissioned places for community children's nurses, despite their being plenty of candidates for such places." (p1).
[40] Q228.
[41] Q237.
[42] Ev. p 16, Annex D.
[43] Q305.
[44] Ibid.
[45] Q314.

turn them into "a special new sort of doctor."[46] Graduate entry might be a cost-effective way of broadening the recruitment base for medicine and expanding the total intake. In post-graduate education there is need for a system more in tune with rapidly changing health service demands. **We suggest that DoH should ask the MWSAC to look in more detail at the balance between specialist and generalist training for doctors in achieving a flexible medical workforce.**

Skill Mix

40. Current or future planning mechanisms will increasingly need to consider the matter of skill mix. MWSAC has made reference to skill mix in each of its three reports. Its Chairman told us:

> "We have in our earlier reports hammered on about skill mix and my personal observation is that the country has not made as much progress as one might wish."[47]

41. We would like to see the NHS undertake further research on the issue of skill mix. In an article discussing substitution of staff, Gerald Richardson and others agreed that:

> "To estimate the level at which doctors can be substituted with other health professionals in the UK would require a multi-centre randomised controlled trial with careful measurement of costs and patients' outcomes and an adequate follow-up period."[48]

This would be a complex and expensive exercise, but:

> "These costs may be small when compared to the potential savings available from substituting other health professionals for doctors and the potential costs (including damage to patients) of changing skill mix in the absence of a sufficient knowledge base. It is surprising that such evaluations have been absent when skill mix in many countries has been altered radically."[49]

42. We further believe that alterations in the skill mix might have benefits beyond simple value for money savings. In their analysis of the UK nursing market, James Buchan and others contend that:

> "In the absence of agreed and robust outcome measures, decisions on staffing mix are being based primarily on considerations of cost...Some research suggests that there is a direct relationship between the grade mix of nursing staff used and measures of the quality of care, with a 'richer' skill mix leading to higher quality of care."[50]

43. Some education consortia have anticipated the trend and commissioned research. The Chair of the Isle of Wight Local Education Consortia told us:

> "Our consortium is trying to undertake some visioning on what the future educational development needs of nursing in primary care are going to be from a five year perspective, particularly taking into account the information we have had about the lowering numbers of GPs in the future. We have commissioned that research."[51]

44. In 1997 the Audit Commission recommended the instigation of pilot schemes to assess the feasibility of nurse anaesthetists.[52] We believe it is high time that a major evaluation of all the potential areas that might benefit from skill mix and substitution was undertaken in the UK. The exercise should not rely on the initiative and innovation of individual education consortia.

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[46] Q99.
[47] Q75.
[48] *Skill mix changes: substitution or service development?:* Gerald Richardson, Alan Maynard, Nicky Cullum and David Kindig, Health Policy 45 (1998), p127.
[49] Ibid.
[50] *Nurses Work : An Analysis of the UK Nursing Labour Market:* (Developments in Nursing and Health Care 18), James Buchan et al.
[51] Q304.
[52] *Anaesthesia Under Examination*: Audit Commission, 1997.

45. We recognise that the Government is not solely responsible for the inflexible roles of the various professions staff in the NHS. We believe that the Government's work could be greatly assisted by dialogue between groups representing staff in the NHS aimed at removing entrenched professional boundaries and 'territorial power rivalries' which even today inhibit progress and change.

46. It appears that skill mix reviews are driven by local management initiatives which result in local and parochial solutions some of which are contingent on other factors such as shortages in the labour markets, budget pressures and establishment costs. This does not lead to a co-ordinated strategic approach to assess the impact of these local approaches on the overall impact on the workforce requirements.

47. Responsibility for organisational development within the NHS is blurred. There is a need for health professionals along with the NHSE, Health Authorities, and trusts to design, implement and evaluate new patterns of service provision including ones that entail significant changes in skill mix. We welcome the development of a flexible workforce, so long as 'flexibility' does not become an arbitrary tool in the hands of employers. An appropriate strategy acceptable to patients, staff and employers must be worked out. **We recommend that efforts are made to co-ordinate local initiatives and assess their strategic impact on the future workforce numbers. We further recommend that co-ordinated pilot studies are undertaken to assess the impact of altering the skill mix.**

Doctor Numbers

48. The Government has accepted the recommendation contained in MWSAC's Third Report that intake into medical schools be increased by 1,000 per annum. This amounts to a 20 per cent rise.[53] A major factor in medical workforce planning is the extent to which the UK has become dependent on overseas qualified doctors.

49. In its memorandum to us the Joint Consultants Committee noted that:

> "The General Medical Council reports that the majority of new registrations last year [1997] were from overseas."[54]

It pointed out that EU countries plan to reduce their current overproduction of doctors, thereby limiting the numbers available for recruitment to the UK from Europe.

50. The British Medical Association (BMA) believed that the UK:

> "Must aim towards self-sufficiency in medical staffing; reliance on doctors from overseas, particularly from developing countries which need their expertise, is not an acceptable strategy."[55]

The BMA also argued that there has been inadequate consultant expansion following on from a change in training programmes and increased patient throughput:

> "The problem is compounded by an increase in the number of consultants seeking early retirement from the NHS."[56]

51. The recruitment of doctors into general practice is also not without its problems.[57] DoH officials were confident that matters here were improving,[58] although the full impact on GPs of the development of Primary Care Groups remains uncertain.

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[53] Ev. p5, para 4.5.
[54] Appendix 28.
[55] Ev. p 63.
[56] Ibid.
[57] Ibid. See also Appendix 15.
[58] Q60.

52. A recent article in the British Medical Journal drew attention to the impact over the next decade of the retirement of general practitioners who qualified in South Asia,[59] a source of recruitment not likely to be available in the future.[60] This group represents one in six practising GPs of whom two-thirds are likely to retire by 2007. The distribution of these doctors varies. The greatest number are in some of the most deprived areas of the UK, where filling vacancies can be difficult. The authors of the article concluded:

> "Various responses will be required by workforce planners to mitigate the impact of these retirements."[61]

53. In a supplementary memorandum the BMA analysed trends pointing to a potential future and accelerating shortfall of doctors. The immediate past Chairman of the BMA told us that his organisation had :

> "Thought we honestly needed 2,000 more [medical students] per annum. Campbell [Chairman of MWSAC] said 1,000...our reply was 'that will be a lot better than nothing'."[62]

54. The MWSAC based its recommendation on an anticipated annual wastage rate of 3.3 per cent and a growth demand of 1.7 per cent of doctors in the NHS. Past figures are in excess of these percentages and achieving this wastage rate is regarded by MWSAC itself as challenging.[63] We do not believe that this will be achieved given the expected demographic changes in the profession. If current trends continue, and if a progressive impact is to be made on reducing dependency on overseas qualified doctors, the increase in the intake to medical schools will need to be in excess of 1,000.

55. The MWSAC calculated that the cost of increasing the annual intake of medical students by 1,000 would be around £200 million a year.[64] The Chairman of MWSAC told us candidly:

> "There is no point writing a report which cannot be afforded in any sector in this country."[65]

56. We recognise that, ultimately, the terms of reference of MWSAC require it to take account of resource implications.[66] Affordability is a political decision. We firmly believe it is in this country's best interest to pursue a more ambitious path towards greater self-sufficiency in doctors and to ensure that expanding demand for medical services, including the appropriate training and supervision of junior doctors, can be met. MWSAC too were of the same opinion.

> "We favour *self-reliance* as a long term goal, that is relying largely upon UK doctors although not aiming for a workforce comprised entirely of UK doctors."[67]

57. The MWSAC gave careful consideration to the risks associated with under and over-supply. An increase of 1,000 in the annual medical school intake, in the view of MWSAC, would not produce a domestic over-supply by the year 2020 under any realistic scenario. It should be noted that past predictions and actual increases in medical student intakes have consistently fallen below demand for doctors in the UK. The consequence is the current need for a substantial increase in medical student numbers. Because small percentage point shifts in wastage and growth rates over

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[59] *Retrospective analysis of census data on general practitioners who qualified in South Asia: who will replace them as they retire?,* by Donald H Taylor Jr and Aneez Esmail, BMJ, No. 7179, 30 January 1999, pp 306-310.
[60] Ibid, p310.
[61] Ibid, p306.
[62] Q114.
[63] *Planning the Medical Workforce* ,Medical Workforce Standing Advisory Committee: Third Report, December 1997, p3.
[64] Ibid, p40.
[65] Q84.
[66] Q83.
[67] MWSAC: Third Report, p3.

time have large effects on the number of medical graduates required these indices need to be kept under constant review.

58. We believe existing medical schools may have difficulties in accommodating the minimum extra intake of 1,000 medical students. There may be a need for new medical schools and new types of graduate courses and this need will become urgent as the expansion in intake exceeds 1,000.[68]

59. **We recommend that the proposed number of medical students be increased by a minimum of 1,000 per year. This increase should be accompanied by a commensurate expansion in the number of senior doctors and consultants in order to provide for the necessary career opportunities and supervisory roles.**

Nurse Numbers

60. In a memorandum to us on medical and nursing staff in the NHS the DoH said:

> "With the extra money that is being made available, the NHS will be able to take on more doctors and more nurses - up to 7,000 more doctors and 15,000 more nurses over the next three years."[69]

This suggests that the numbers are cost derived rather than service driven. The DoH later informed us that in their view there was a scientific approach to the figures based on present assumptions of current and future needs, bed activity, waiting lists, participation rates, vacancy levels and trends in healthcare.[70]

61. The Secretary of State for Health told us:

> "Taken nationally...looking at various figures from various sources...there are probably 9,000 or so nursing vacancies which have been vacancies for three months or more - in other words, serious vacancies and not just turnover."[71]

Others have calculated that the figure is higher.[72]

62. The written evidence we received, the oral evidence we took from staff representative groups and our informal discussions all revealed disturbing staff shortages in the NHS.[73] Mr Andrew Foster of the NHS Confederation told us:

> "It is undoubtedly the case that in all areas at the moment the ratio of staff to patients has declined substantially over the years and that is a significant cause of the problems and stresses that are faced by the system at the moment."[74]

63. Miss Christine Hancock of the RCN explained some of the causes of NHS nurses moving into the private sector:

> "Most nurses believe passionately in the Health Service. In my experience, the private sector does not have a labour market of nurses who like private medicine but they drift into it for a variety of reasons, hours, accessibility, a job going...and when they get there one of the things they always say is that they are able to nurse patients properly...what they can do is they can give the patient care that they trained for and they believed in...One of the biggest things...that drives clinical staff out of the NHS is the feeling that they are not able to care for patients properly and they are not able to do their job

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[68] This was an option put forward by MWSAC, ibid, p4.
[69] Ev. p26, para 6.3.
[70] Appendix 71.
[71] Q322.
[72] The RCN believes there are 12,000 vacancies.
[73] See, for example, ev. p69.
[74] Q251.

properly."[75]

64. The decrease in training places for nurses over recent years has caused the number of qualified nurses registering to reduce from 32,143 in 1993-94 to 26,465 in 1997-98.[76] The midwifery statistics for the same period show a decline in the number of midwives re-registering on an annual basis from 105,723 in 1993-94 to 93,776 in 1997-98.[77] The Government's proposed reforms, and a reduction in doctors' hours, will increase both the demands on staff and the numbers needed to deal with the changes in approach that will result. **The evidence we have received leads us to conclude that on current trends the projected increases in the number of nurses and other clinical staff fall well short of what is required to deal with current shortages and future developments in the NHS. We hope that recent Government initiatives will reverse these trends, but we suggest that the Government urgently reassesses its staffing figures to ensure an NHS workforce that is sufficient for requirements.**

Efficiency Measurement

65. During oral evidence Mr Andrew Foster of the NHS Confederation spoke of the adverse effects of the need for trusts to adhere to the efficiency index which requires year on year improvement of 2.5 to 3 per cent in productivity. The consequence of this, he said:

> "is a critical, undermining factor to the experience of working in the NHS nowadays."[78]

66. Mr Foster argued that even with no slack in the system annual productivity gains were still expected.[79] We believe that such an attitude hinders rather than assists the efficient use of resources and inhibits effective working. It creates an atmosphere of anxiety and pressure which is unlikely to lead to productive change. We believe that it is important that a watchful eye should be kept on potential efficiency savings. The way to achieve this is to target areas where efficiency gains can legitimately be made.

67. We note the Secretary of State's view that:

> "Where two hospitals have broadly speaking the same sort of capital investment, the same sort of population, the same sort of folks working there and one is costing 30 per cent more than the other, there is something wrong and it has to be addressed."[80]

In our view it is extremely difficult to assess the basis of costs between different hospitals on current data. Higher costs may be due to a more complex mix of patients, higher quality of care or the location of the hospital on a capital rich site. They may also be the result of initiatives such as leaving a theatre spare for emergency work or keeping beds available for emergency admission, which we would consider to be good practice.

68. We were encouraged to hear that DoH is targeting demands for efficiency savings.[81] But the annual efficiency index is mechanical and appears to place unrealistic demands on both staff and employers.[82] **We recommend that the Government consults with NHS employers and staff representative groups in order to establish a rigorous but fair system of efficiency appraisal.**

Data Collection

69. Accurate data is a prerequisite of good planning practices. But, there is widespread criticism

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[75] Q144.
[76] UKCC Annual Statistics 97/98.
[77] Ibid.
[78] Q251.
[79] Ibid.
[80] Q364.
[81] Q366.
[82] Qq251 and 252.

in the memoranda of the collection and availability of reliable data.[83] The NHS Confederation stated:

> "We need to work towards using the same data/statistical information sources when looking at NHS staffing issues. This causes confusion, for example, in the annual Pay Review Body evidence submissions there can be a number of different sets of data quoted in response to the same issue."[84]

70. Professions Allied to Medicine argued that:

> "We believe that a central NHS Workforce Data Collection and Analysis Unit should be established by the NHSE. All social partners should be consulted and involved in its work. This Unit should collect, collate and publish workforce statistics for the whole Service. The data promulgated could inform Review Body, local providers, HIPs and education consortia decisions, amongst others. It should be made a requirement of local employers in all sectors of the Health Service, including primary care, to provide workforce statistics. These should be locally collected by professional heads each year."[85]

71. These criticisms were sustained by a variety of witnesses. Mr Richard Griffin representing PAMs told us:

> "We are in the situation at the moment where the Executive is not even gathering the vacancy information; so if you do not know where you are at the moment it is very hard to predict where you are going in the future."[86]

72. Miss Louise Silverton, Deputy General Secretary of the RCM explained:

> "the reason that we have to have our own data is that the Department of Health data is actually so poor... NHS statistics are poor at various levels throughout the organisation, not only the central ones, but even at trust level."[87]

Sir Alexander Macara, Immediate Past Chairman of the BMA said:

> "we would not rely on Department of Health statistics"[88]

73. DoH recognised the concerns.[89] The Director of Human Resources at NHSE told us:

> "I think there is an issue about communication and discussion about the information that we have. We are open to talk about it and I would welcome that. If there is a feeling of frustration I would want to talk to the organisations concerned."[90]

74. A review in 1997[91] recommended in the short-term some streamlining and improvement in the coverage of health professional workforce planning information. In the longer term it recommended that there should be an enhanced role for consortia in data collection, and the development of good practice guidelines. Three pilot studies are currently reviewing workforce

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[83] See for example the written evidence submitted by : Royal College of General Practitioners - Appendix 15, Royal College of Nursing - Ev. pp 89-101, Professions Allied to Medicine - Ev. pp73-77, Conference of Clinical Scientists' Organisations - Appendix 16, Council of Science and Technology Institutes - Appendix 63, Institute of Physics and Engineering in Medicine - Appendix 61, UNISON - Ev. pp101-110, National Council for Hospice and Specialist Palliative Care Services - Appendix 19, NHS Confederation - Ev. pp161-165, and Chartered Society of Physiotherapy - Appendix 22.

[84] Ev. p161.

[85] Ev. p74.

[86] Q118.

[87] Q119.

[88] Ibid.

[89] Ev. pp10 and 23.

[90] Q31.

[91] Ev. p23.

information flows. The project aims to report in summer 1999.[92]

75. An example of the confusion which currently exists in the various sets of health service-related data was apparent in the written evidence we received. In its memorandum Professions Allied to Medicine referred to the high level of staff turnover in the NHS, which it believed to approach 20 per cent per annum for PAMs.[93] Pay and Workforce Research (PWR), which is part of the NHS, sent us its recent report on NHS staff turnover. In a covering letter the Director noted that:

> "One of the surprising results of the survey is that contrary to public perception of retention problems in the NHS, turnover is generally quite low compared to most other industrial sectors. This would of course, bring into question the cost effectiveness of attempts to improve retention."[94]

The turnover rate for all groups was given as 12.5 per cent.[95] PWR claimed that the highest rate of turnover related to medical and dental staff - 19.2 per cent annual equivalent, followed by healthcare assistants - 18.5 per cent annual equivalent. But the figures refer to different processes. Doctors and dentists change trust employers as part of planned training programmes. This is not the case for healthcare assistants. The confusion on data may well contribute to differences in the perception of staff morale in the NHS.

76. We accept that the DoH has to:

> "balance the value of the information against the burden placed on the Service in supplying the data."[96]

But there has to be some consensus about the validity of the statistics being used. The alternative, particularly during discussions on workforce requirements or pay negotiations, is akin to an international summit listening to contributions made in a variety of tongues without appropriate interpretation.

77. We have already drawn attention in paragraph 70 to the suggestion from Professions Allied to Medicine that there should be a central NHS workforce data collection and analysis unit. When we put this point to the DoH officials, the Director of Human Resources at the NHSE argued that this was already in place.[97] But this viewpoint was contradicted by the evidence we took during the course of the inquiry.[98] It is our view that data and collation in this area is inconsistent and fragmentary. It manifestly does not inspire confidence so far as NHS employees are concerned.

78. Mr Bob Abberley of UNISON argued for a review of:

> "How we get information collected in the NHS which all the social partners are prepared to accept as being accurate information."[99]

He suggested a pooling of data from all concerned parties.[100] Reaching consensus on statistical provision is fraught with difficulties particularly in an increasingly fragmented service. It may well be that the three pilot projects set up to review current practice with regard to the gathering of information for workforce planning and to identify the extent to which workforce planning systems

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[92] Ibid, para 3.
[93] Ev. p74.
[94] Appendix 74.
[95] Ibid.
[96] Ev. p9.
[97] Q31.
[98] See, for example, memoranda from the Royal College of Nursing - Ev. pp 89-101, PAMs - Ev. pp73-77, Council of Science and Technology Institutes - Appendix 63, UNISON - Ev. pp101-110, National Council for Hospice and Specialist Palliative Care Services - Appendix 19 and The Chartered Society of Physiotherapy - Appendix 22. See also Qq 118 and 119.
[99] Q122.
[100] Ibid.

link with the business planning process,[101] which are due to report later this year will yield an appropriate way forward.

79. We asked the Secretary of State for his view on the idea of exit interviews to determine more accurately the reasons for staff leaving the NHS. He said:

> "I am certainly in favour of doing anything we can to find out why staff are leaving, and to find out the attitude of people who have left and who might or might not be thinking of coming back."[102]

It seems to us that the introduction of formal exit interviews would help workforce planning by providing a better sense of the reasons why staff leave the NHS. We also recommend that DoH initiate a formal consultation on standardisation of information as soon as possible. It is our hope and expectation that in the very near future all debate on the NHS should be informed by universally accepted figures.

Recruitment and Retention

80. The Government's framework for managing Human Resources in the NHS entitled *Working Together - securing a quality workforce for the NHS* was published in September 1998. One of the Government's stated aims was to:

> "recruit and retain a workforce which has the capacity, skills, diversity, and flexibility to meet the demands on the Service."[103]

81. The DoH reinforced its comments in written evidence to us when it asserted that:

> "The NHS remains an attractive and secure career and the vast majority of posts attract competition from people wanting to fill them."[104]

But, in stark contradiction to this statement, DoH acknowledged that there were staff shortages in nursing, physiotherapy, occupational therapy, anaesthesia, psychiatry and pharmacy. Its approach to tackling the problems was to increase training, target health professionals to resume their careers, broaden career structures, and improve the working environment.[105]

82. These are admirable intentions. The Government is taking steps to address seriously most of the issues of concern which we have raised. It aims to end the routine use of short-term contracts, except for bona fide reasons such as the provision of cover for maternity leave, and to improve the recruitment of ethnic minorities.

83. Racism in any sphere is intolerable. Miss Christine Hancock of the RCN told us:

> "In gender and in race issues the NHS is quite often nothing short of a scandal. And I think that that is not only bad for staff, but it also affects the way patients are treated."[106]

Increasing the recruitment of nurses from ethnic minorities we regard as being of particular importance. Current low levels of recruitment were ascribed by witnesses to previous discrimination against nurses from the ethnic minorities in respect of promotion and working conditions. We welcome the Government's proposals to combat racism in the NHS; we believe that it is essential that steps are taken to overcome negative perceptions of nursing in the NHS on the part of potential recruits from ethnic minorities. **Since the NHS will continue to rely on overseas staff for many years to come, it is important that the Service ensures their career opportunities are not being restricted by their immigration status. We recommend that DoH**

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[101] Ev. p23, Annex F, para 3.
[102] Q335.
[103] Para 2.3.
[104] Ev. p5, para 4.4.
[105] Ibid.
[106] Q117.

consults with the Home Office and the Department for Education and Employment on these issues.

84. It will take time for the full impact of the plans to be felt. Provided the Government maintains both its commitment and momentum towards reform, we would expect to see marked improvement in the NHS before long, although we do not underestimate the difficulty even with an improvement in career prospects, working conditions and pay of attracting the necessary numbers of staff into the NHS. We would, however, like to draw attention to some of the evidence we received during our investigation.

85. A press notice from the BMA of 5 November 1998 announced that:

> "One third of doctors would not choose medicine if they were starting their careers now and more than four in ten would not advise school-leavers to choose it as a profession."

Thanet Healthcare NHS Trust explained that their:

> "ability to recruit and retain nurses is a constant pressure point and shortages of trained nurses and other key skills within the hospital does certainly add to an already stressful environment."[107]

Thanet Healthcare NHS Trust also described its inability to recruit people in Professions Allied to Medicine which led to the need for additional hours being worked. [108]

Professions Allied to Medicine, Pharmacists and Scientists

86. The memorandum from Professions Allied to Medicine described the most severe recruitment and retention difficulties in their group as relating to occupational therapy, physiotherapy and dietetics.[109] It went on to say:

> "In November 1996, the Incomes Data Services (IDS) produced a report into recruitment and retention in the public sector. This found that 'by far the worst recruitment and retention problems in the NHS were concentrated in the PAM professions, particularly physiotherapy. In February 1997, the Audit Commission released its report 'Finders Keepers: The Management of Staff Turnover in NHS Trusts'. This found that turnover was significantly worse in physiotherapy (from 8% - 76%) in comparison to nursing and administrative and clerical posts."[110]

The same memorandum also spoke of the need to stem the flow of PAMs from the NHS or Government proposals "will be extremely difficult if not impossible to realise."[111]

87. In oral evidence Mr Richard Griffin representing PAMs developed this evidence:

> "The junior doctors' reduction in hours does mean our members are taking greater responsibility, are taking on more and more work. Also, the demand for PAMs will increase, it will increase because of the Government's priorities in terms of the emphasis on rehabilitation, in terms of the expansion of primary care. PAMs have increased in the NHS by 26 per cent over the last ten years; we would anticipate that rise will continue in terms of the demand, but the real question is, where will those members, where will those staff actually come from?"[112]

88. We have heard evidence of a large number of recruitment problems with scientists and PAMs. During our visit to the Royal Hospitals NHS Trust we were told that there is a shortage of

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[107] Appendix 35.
[108] Ibid.
[109] Ev. p73.
[110] Ev. p74.
[111] Ev. p77.
[112] Q112.

bio-medical scientists and medical laboratory scientific officers who suffered particular difficulties with regard to their salaries and inadequate numbers of staff to allow for proper training. We were told that the starting salary for a graduate in these professions could be as low as £7,500.[113] Mr Roger Kline of MSF said:

> "Medical laboratory scientific officers can get jobs in the private sector, so one of the key issues for them is they can get more much more in the private sector, sometimes I do wonder why on earth a medical laboratory scientific officer should go and work in the Health Service."[114]

89. Speech Therapists are a further group with particular retention difficulties. At the Royal London Hospital we were told that downscaling was a problem and that there was an absence of experienced personnel. We heard that in many disciplines shortages of fully trained staff meant that there was even less time available for experienced staff to train others. Such problems occurred, for example, with diagnostic imaging technicians and cytology technicians.

90. The Committee were also told by members of the PAM professions that career pathways had become blocked and needed freeing. There was no way of rewarding a good competent professional other than in management. Ms Jocelyn Prudence representing PAMs told us:

> "the career structure that we are operating to was created in 1974 so it does not bear any relationship with the modern NHS."[115]

91. The memorandum from DoH drew attention to the PAMs career development initiative, which it said at national level is:

> "Informing initiatives in areas such as HR Strategy, Education and Training Strategy and the National Development Framework".[116]

This is fine so far as it goes, but the Professions Allied to Medicine are experiencing exceptional problems in the NHS, particularly in respect of the limited opportunities they have to develop their careers and the degree of overwork to which they are subjected. Many of this group of staff would find it relatively easy to find alternative employment outside of the Service and increasing numbers are taking up options in the private sector.[117]

92. The recruitment of pharmacists is already suffering as a consequence of the greater attractiveness of work outside the NHS. The Chief Pharmacists Group (West Midlands) told us that pharmacists are increasingly attracted by careers outside hospital work, because:

> "differentials between hospital and community pharmacy salaries are now far too wide."[118]

The summer of 2000 will be a 'fallow year' for pharmacists following the extension of the degree course in English schools of pharmacy from three to four years. The Chief Pharmacists Group (West Midlands) added that:

> "If we have not found a solution to the problem of hospital pharmacist recruitment by May/June 1999 when the students whom we hope to recruit for commencement of pre-registration training in August 2000 are considering their options, then hospital pharmacy practice will have to be placed on the critical list."[119]

93. A report on recruitment and vacancies amongst hospital pharmacy staff in Great Britain

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[113] Q200.
[114] Q141.
[115] Q174.
[116] Ev. p15, Annex C, para 6.
[117] See, for example, Ev. p75.
[118] Appendix 45.
[119] Ibid.

submitted to us by the Chair, NHS Pharmacy Education and Development Committee, indicated that there are:

> "a large number of vacancies, that...are hard to recruit to, and that the position is markedly worse than it was two years ago."[120]

We therefore urge the Government to collate information from trusts in order to allow them to formulate a specific recruitment and retention strategy for pharmacists, scientists and all of the Professions Allied to Medicine as soon as possible.

UKCC Trends

94. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) regulates those professions throughout the UK. UKCC sent us its statistical analysis covering the year to March 1998. This revealed that: the admission to the register of qualified nurses and midwives were at their lowest level since records began in 1984-85; the shortfall in domestic recruitment was partly offset by the high number of overseas- trained practitioners registering to work in the UK, which was also at a record high; of those practitioners coming from abroad to work in the UK the main source countries were, Australia, New Zealand, South Africa, Finland, and the Republic of Ireland; the number of midwives trained in the UK and registering for the first time was at its highest level for four years; the number of practising midwives was at its lowest level since records began. Almost half of midwives work part-time and there is a sharply rising trend towards part-time working in the profession; for the first time, more than 50 per cent of all those on the register are aged 40 or over. We also note there is a well-established rising age profile on the register.[121]

Foreign Nurses

95. The UKCC commented on the recruitment of large numbers of overseas nurses and is considering undertaking some joint research on the subject with the NHSE which it hoped would help workforce planners. It said:

> "There has to date been no research into whether this is a cost- effective or sensible way of filling the recruitment gap."[122]

Such research may, UKCC believed :

> "demonstrate that, for example, it would be more cost-effective to provide a creche in a Trust for the children of five returners than recruit staff from overseas."[123]

96. This is a plausible hypothesis. We were concerned at the high cost of recruitment of overseas nurses, mainly paid to agencies. We do not think it acceptable to solve our nursing shortages by this means if we are creating shortages in developing countries. We can imagine scenarios in which a planned partnership between two countries would lead to planning our workforce on the basis of a level of foreign nurse support. We realise trusts have to resort to *ad hoc* recruitment of foreign nurses, but from comments made by staff we are suspicious that not enough was done in some areas to give extra support and incentives to local nurses before resorting to recruitment from abroad. Where foreign staff come for just six months the time spent in necessary orientation is disproportionately high and is a cause for concern. We would always support some exchange of nurses between countries, but we believe it is essential that the root causes of the shortages that have led to increasing levels of overseas recruitment are tackled.

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[120] SR83.
[121] Appendix 69.
[122] Ibid.
[123] Ibid.

Family-Friendly Policies

97. The Government has committed itself to the introduction of a whole range of family-friendly policies. Child care facilities, flexible hours and job share opportunities are obvious examples of areas where improvements could be made, particularly with regard to the working lives of parents with childcare responsibilities who are on current patterns predominantly women. Currently over 50 per cent of medical graduates are women.[124] We do not though underestimate the logistical problems of introducing such provisions, but the fact that the NHS operates a comprehensive 24-hour service gives opportunities to do just this. Persistent staff shortages are sometimes cited as an obstacle to the implementation of family-friendly policies; but the absence of such policies is itself a major factor in creating such shortages. A determined effort needs to be made to break into this cycle.

98. A briefing paper provided by the RCN during our visit to the Royal Hospitals NHS Trust said that:

> "Most [staff] feel that not much more than lip service is paid to the development of Family-Friendly policies."[125]

Miss Louise Silverton of the RCM thought that:

> "whilst with rhetoric some management may say they do have family-friendly policies, the number of places in creches is very small...The introduction of 12 hour shifts has made it very difficult for working mothers to combine motherhood and working."[126]

Miss Christine Hancock of the RCN noted that:

> "one-third of all NHS nurses are working internal rotation and that has gone up from 23 per cent in 1994 and two-thirds of those working internal rotation say it is not their preferred pattern of work."[127]

99. We heard evidence from many staff on difficulties resulting from internal rotation. Internal rotation occurs when nurses and midwives are obliged to change their shift patterns across the full 24 hours. The way that the rotation is worked varies from trust to trust. The dissatisfaction occurs when staff, for personal reasons, have elected to work day duty (am and pm) or night duty and are then forced to work on the opposite shift, causing great disruption to their personal and family life. The rapidity of changes in some trusts causes particular problems.

100. The DoH memorandum stated:

> "The NHS...needs to become a smart employer by understanding that all staff need to be better able to marry their work and their out of work responsibilities. Six out of 10 nurses have caring responsibilities. The Government will work with NHS employers, trade unions, and others with experience in this area to develop a national approach to support the health service in implementing more supportive, family-friendly employment policies for staff."[128]

101. The key phrase here is 'a national approach'. Whilst we endorse the direction of the Government's policy, and accept the need for a local dimension to be built into the overall strategy, the evidence we have heard during the inquiry has not convinced us of the readiness yet of all individual trusts to introduce the required policies. This will require further firm action.

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[124] Ev. p155.
[125] SR94.
[126] Q179.
[127] Q183.
[128] Ev. p8, para 4.29.

NHS Management

102. The current style of management in the NHS came in for a good deal of adverse comment during our discussions. A psychologist in Darlington told us he believed that there was "self imposed ignorance" at the top. During its visit to Birmingham we heard that the move to trust status had created a more aggressive, insensitive managerial approach, uncaring and unheeding of staff who were treated like 'cannon fodder'. There was a strong feeling that trusts should begin to realise how staff felt and to consult them properly. One recommendation was that each trust board should contain a member of staff. During the evidence session with DoH officials on 26 November the Head of Workforce Planning said:

> "Trust nurses are at board level within trusts and have a tremendous opportunity to influence the whole of the organisation."[129]

Mr Bob Abberley of UNISON believed that:

> "when staff talk about staff involvement they mean about decisions in the ward...I do not necessarily think that, if you had someone on the board but you did not have staff involvement in the ward, it would change anything."[130]

103. In its memorandum the NHS Confederation announced that:

> "NHS organisations are committed to good employment practices and to improving the working life of all staff working within the NHS."[131]

Mrs Heather Ballard of the CDNA described NHS management as:

> "a horrific thing...many of our members around the country...are frightened...they are working in cultures of fear."[132]

Miss Louise Silverton of RCM argued that there now existed: "a whole generation of managers who were appointed and brought up in that [the internal market] environment." whose pressures had created poor practice. Inculcating a cultural change would, she believed, "be a very major exercise."[133]

104. Mr Roger Kline of MSF, believed that:

> "the internal market, particularly the short-term contracts, the pressure to emphasise finance at the expense of quality, which hopefully is something that will gradually change...has created a culture of fear for managers, so that managers themselves have [developed an attitude of] 'I've got to deliver, I've got to bully you into doing it.'"[134]

This was a view echoed by Sir Alexander Macara, representing the BMA.[135] A contributory factor to this was the gagging clauses which had been a feature of trusts' contracts. The Government's insistence on the removal of gagging clauses from NHS staff contracts should materially reduce this problem.

105. The Director of Human Resources at NHSE acknowledged the need to develop "managerial leadership capacity in the NHS'. He told us that:

> " In a time of turbulence and change...it is very important that staff are given adequate leadership...What we want are leaders who are inclusive in their style, who involve their

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[129] Q18.
[130] Q126.
[131] Ev. p161.
[132] Q150.
[133] Ibid.
[134] Q151.
[135] Q154.

staff and give them real leadership through a period of change."[136]

DoH has recently launched a leadership development programme for chief executives and leadership training programmes are available to senior medical staff and nurses. The belief is that more effective training should be developed and we endorse this initiative.[137]

106. There clearly has to be an immediate and fundamental alteration to the management culture in trusts. Staff involvement is crucial to progress in this area. A working climate which encourages participation in the decision making process amongst its staff is bound to benefit from improved morale. The DoH knows this. The Director of Human Resources at NHSE told us that although the new HR framework required the systematic testing of staff attitudes and concerns an appropriate methodology had not yet been devised.[138] A Taskforce has been set up to identify and explore new approaches to staff involvement and disseminate best practice.[139]

107. Involving staff in decisions that affected them would almost certainly prove to be beneficial for the Service. For example, on matters related to difficult or unsocial shift patterns perhaps involving internal rotation, allowing staff the opportunity to arrange a timetable amongst themselves, with suitable oversight and guidance, would, we believe, help to improve morale. DoH believes that self-rostering:

> "May have considerable potential for developing working practices to fit in with a wide range of caring responsibilities whilst meeting service needs."[140]

108. In written evidence Professor Sir Colin Campbell, Chairman of the Medical Workforce Standing Advisory Committee suggested that:

> "It might be worth looking again at the role of clinicians in management. It may be that clinical management could bring about more effective delivery of high quality service. The result of reforms in the last decade have led to a number (an excessive number) of non-clinical managers devoted to the notion of management rather than to the NHS and what it stands for."[141]

Managers must have demonstrable skills that are directly applicable to the NHS. They should be committed to staff involvement in decisions and improvements in staff morale if there are to be long-term benefits to patients. We would not wish to perpetuate the conditions whereby the only route to senior promotion for the majority of NHS staff is via management. Those with clinical ability who wish to advance in that setting should be allowed the opportunity to do so.

Nurse and Midwifery Training

109. In commencing this section we wish to acknowledge the separate nature of the two professions under discussion. They are grouped here for reasons of concision. The majority of nurses are currently trained under the Project 2000 programmes. These were first established in 1989 following work carried out by the UKCC. The UKCC and the government of the day were clear that the education of nurses should not be significantly removed from the patients' bedside, but should be supplemented with a sound educational underpinning.

110. Project 2000 has been criticised for being too academic. Certainly it has resulted in nurses' direct experience with patients being delayed. One consequence of this has been the wholesale removal of new student nurses from wards. These lost hands have been replaced by alternatives in the form of healthcare assistants.

111. However, patient care in hospitals is increasingly sophisticated. It requires greater use of

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[136] Q16.
[137] Ibid.
[138] Qq2 and 3.
[139] Ev. p8, para 4.30.
[140] Ev. p14, Annex C, para7.
[141] Ev. p61.

high technology and requires nurses, who are the main carers over any 24-hour period, to be educated in these fields. **We would encourage education consortia, universities and the NHS to collaborate to ensure that the opportunity exists for student nurses to experience clinical practice in a safe and supervised environment as early in the training programme as possible.**

112. It is important to create as many access routes to a nursing or midwifery career as possible. No one with a vocational competence should be excluded. It is our view that one way to achieve this is via NVQs. We welcome the recent Government initiative to help 1,000 health care assistants train as registered nurses. The RCN, whilst advocating the award of a first degree as the goal of nursing education said:

> "The Government's recent emphasis on widening the entry gates to nursing, including bursaries for enrolled nurses to retrain and return to the NHS, special bursaries for existing NHS staff, such as health care assistants, to enable them to train as nurses, and more part-time pre-registration nursing and midwifery courses are particularly welcome. The RCN believes that a greater emphasis on NVQ level entry to nurse education, coupled with fast-tracking for experienced health care staff, could also give wider access to nursing as a career."[142]

113. The UKCC is currently reviewing pre-registration nursing and midwifery training through a Commission for Education which is due to complete its work in the summer of 1999. Its work will clearly have an important influence on recruitment and retention practices. We hope that the use of NVQs and modules of training will feature largely in its recommendations.

114. During our visit to Birmingham we learned of the Cadet Nursing Scheme which was being run by Sandwell Healthcare Trust.[143] The scheme started in September 1997. It was developed after the Trust had experienced recruitment difficulties with qualified nurses. It provides pre-qualification training and sponsored professional training. There is open entry to the course. In the absence of relevant qualifications a written test equivalent to GCSE level maths and English which is acceptable to Wolverhampton University is undertaken. The programme is based on NVQ standards which have criteria and learning outcomes. Each cadet is required to give a written undertaking to work for the Trust as a trained nurse on completion of training, otherwise a percentage of the cost of training is refundable. Cadets receive early experience of work on the wards. Their progress is monitored with a view to assessing suitability for eventual entry into the Project 2000 programme.

115. We consider that an advantage of such a scheme lies in the fact that early clinical experience places the subsequent educational setting into a realistic perspective We commend this scheme which demonstrates innovation and initiative. Similar projects could well be tested in other trusts. It is an example of good practice which we hope will be widely shared.

Healthcare Assistants

116. Similar imagination is required in looking at the career progression of healthcare assistants. UNISON believed there were many more healthcare assistants working in the NHS than DoH figures showed.[144] Healthcare assistants perform an essential role in a variety of ways. **We recommend that healthcare assistants working with nurses should be called "Assistant Nurses" to reflect their role and be registered with the UKCC. Healthcare assistants working with other professional groups should also be registered appropriately. Registration in such circumstances would provide professional motivation for the individual and would act as a necessary safeguard for the public who could then be assured that at all times care was being delivered by people whose competence was known and recognised.**

[142] Ev. p100.
[143] Appendix 39.
[144] Ev. p102, para 8.

Grading Structures for Nursing and Midwifery

117. When the current grading and pay structures were introduced, nurses and support workers were graded A – I. There were descriptions for each of the grades, but they were sufficiently broad to allow for a wide variety of opinions regarding which nurse should be on which grade. Consequently, nurses and midwives undertaking comparable roles, but working in different hospitals could (and continue to) receive different grades for their jobs. There was often significant disharmony caused by the grades individual staff actually received, with appeals against designated grades still being heard 10 years later.

118. The grading system has never been very popular. It tried to differentiate between the roles and responsibilities of nurses and midwives within the NHS and to reward accordingly. It took into account such things as: individuals' staff management responsibilities, their capacity to act as a team leader, supervise learners, manage a budget, and give care under supervision. As a rule, a newly-qualified registered nurse was put onto a "D" grade and the most senior clinical manager would be put on a "H" or "I" grade. Some employers would not give "I" grades, in which case "H" became the most senior grade in that hospital or community.

119. Mrs Heather Ballard, Professional Officer, CDNA articulated the anomalies in the current system:

> "What we have not got at the moment in the community is any consistency in terms of grade and skill mix...around the country, there are huge variations which do not seem to bear any resemblance to local needs; you might have one trust where they have a grading structure which consists of B grade auxiliary nurses, D grade staff nurses and G grade district nurses, and, next door, they may well have B grades, Cs, Ds, Es, Fs, Gs, and Hs, and there does not seem to be any rhyme or reason to that."[145]

She later added:

> "There are positive developments in terms of grading and potential for increased earnings with the discretionary incremental points that have just come in and the potential for the nurse consultant, but there is a certain amount of cynicism because of the misuse of the current grading system that we already have."[146]

120. Although Mrs Ballard was enthusiastic about discretionary awards, this view was not shared by all of our witnesses. In written evidence MSF stated:

> "The recommendation of the Pay Review Body in 1998 of a system of discretionary increments added to the top grade of the higher nursing and PAMs grades does not address the problems associated with career progress. This scheme is divisive, discriminatory and does not help those staff on the lower grades where morale is also low. It is hard to find anyone in favour of the scheme."[147]

121. Miss Louise Silverton of the RCM said:

> "Grading, from the point of view of midwives, is a subject where, if you mention it to them, they just groan. The grading structure and the definitions never were appropriate for midwives right back at the beginning. We have been working with something that did not fit and did not work. It has been applied in a way which was cash limited rather than relating to the job that anybody did."[148]

She added:

> "We have an issue of individual trusts deciding they can buck the system so they will pay

[145] Q118.
[146] Q171.
[147] Ev. p70, para 5.
[148] Q173.

> a bit more and we get a roundabout of midwives bouncing from trust to trust following the F grades."[149]

Miss Christine Hancock of the RCN argued that:

> "There is a big difference [in grading] across the country...the south of England has fewer people on the bottom grade than the north of England."[150]

122. We are aware that managers need to assess skill and grade mix and that that assessment leads on occasions to changes in the skill mix of staff. Financial pressures have squeezed the grading system. Posts have been down graded, higher graded posts have been lost and lower graded jobs increased, sometimes in a regrettable way with an impact on the quality of patient care provided. Instead of rewarding staff appropriately it has become a way of controlling budgets. We recognise that when huge pressures are brought to bear on any grading system this is likely to happen. However, in many places there is no confidence in the current grade mixes.

123. An improved system is required. Although we recognise that there are complexities for certain staff and more work needs to be done, we believe it is very desirable to move towards a single pay scale for NHS workers. We will deal with this point when we discuss pay later in the report . Such a scale should be linked to agreed competencies, with a "bar" at various points along the pay scale and incremental points within each "barred" group. We further believe there should be Continuing Professional Development for all staff and ready opportunities for staff to achieve the educational qualifications relevant to their career development.

124. To achieve this each trust would need to carry out detailed workplace planning to define the number of staff they require at what the appropriate level of competence to care for the type of patient they have. Some trusts are already doing this.[151] Such an approach should lead to a wide entry gate and multiple exit points for professional programmes. There would need to be a comparison of occupational standards and levels of competence and academic achievements across the professions.

Working Conditions

125. The Government is determined to reduce violence towards staff in the NHS. But not all of the unwarranted problems confronting staff are the result of direct aggression. The question of patient behaviour arose when we spoke to staff informally. The tension between individual patients' rights and a therapeutic regime for all patients is particularly acute in accident and emergency and psychiatric units. Having to cope with patients' individual routines must cause additional pressure on busy staff. Methods of approaching this sensitive area will need to take full account of the rights of all concerned. The dignity and rights of patients must be maintained at all times, and a degree of independence is likely to aid recovery. But we believe it is reasonable to expect in-patients in hospitals to co-operate in a structure of care that offers them the best possible treatment, takes account of the needs of other patients and promotes due respect to staff who are often over-worked.

126. Staff at the Royal London Hospital also raised the question of the provision of mobile phones for nurses and midwives working in the community. Guidance on reducing the risks from violence and aggression issued to NHS managers and staff by the NHSE and RCN in September 1998 said staff in the community should be provided with the means of contacting base:

> "Methods of communication must be viewed, and evaluated, as tools in both preventative and reactive strategies to reduce the risks for those working in the community. They can assist employees to carry out their normal duties more efficiently and therefore reduce frustration in themselves and their patients; they allow staff to inform base of their

[149] Q174.
[150] Q209.
[151] For example, Ealing NHS Trust.

whereabouts and report at the end of a shift."[152]

127. However, on 10 December 1998 Miss Louise Silverton of the RCM explained:

> " the Service has not supported [midwives] by providing them with appropriate communication links, we have had a lot of trouble trying to get pagers and mobile 'phones, and if you think of some of the high risk areas that midwives work in, delivering a 24-hour service, I would not be very keen to be going out in the middle of the night to some of the poorly lit areas that our members go to."[153]

128. There are growing numbers of NHS staff working in the community. Their colleagues in hospitals or doctor's surgeries have quick access to help and advice. It seems to us unacceptable that managers allow valued members of staff working in sometimes difficult locations and at awkward hours to be without a quick and efficient means of being in contact with the home base or, if necessary, calling for assistance. **We recommend that every member of the NHS staff alone on duty in the community or otherwise at risk should have access to a mobile telephone or other means of establishing emergency contact with colleagues.**

Agency and Bank Staff

129. According to figures supplied by DoH, the financial cost to the NHS in 1997/98 of employing agency nurses was £216,338,567.[154] During a period of acute staff shortages their use has increased dramatically. Using 1997-98 prices the cost to the NHS in 1991/92 was £121,127,306.[155] Contract nurses frequently undertake agency work on their days off in order to supplement their income. (Indeed many staff in the NHS have a second job in order to make ends meet.) Thanet Healthcare NHS Trust told us that like many hospitals it found itself:

> "With our own substantive contract nurses working additional shifts in the hospital via an agency."[156]

130. We received a great deal of anecdotal evidence to support this. Leaving aside the question of the impact of staff fatigue this situation does at least allow the possibility of continuity of care for patients. Mr Bob Abberley of UNISON considered that the biggest threat to patient care was the lack of continuity caused by the use of agency staff.[157]

131. Agency staff whose competence is often unknown are regularly put into stressful and unfamiliar environments where they are not easily able to function as part of a team. Miss Louise Silverton told us:

> "Agency staff cannot deliver continuity of care which is a very crucial thing for the maternity services. More importantly they do seem to disrupt the continuity of care that those employed midwives can give, because it takes them an awful lot longer to make sure that they can assist the agency staff with knowing where things are."[158]

Mr Roger Kline of MSF said:

> "There are as many temporary and bank staff staffing our labs as there are permanent staff, you can imagine the implication for quality of service and clinical governance."[159]

132. We learned during our visit to the Royal London Hospital that experienced nurses working for an agency in a strange hospital were often allocated the most menial role because there was

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[152] *Safer Working in the Community: A guide for NHS managers and staff on reducing the risks from violence and aggression,* by RCN and NHSE, September 1998. See para 3,1.3, p27.
[153] Q147.
[154] Appendix 2.
[155] Ibid.
[156] Appendix 35.
[157] Q160.
[158] Q163.
[159] Q140.

insufficient time or opportunity to involve them appropriately and fully utilise their skills. We also heard of agency staff whose paths crossed on their way to work in each others' contract hospital. This is clearly an absurd situation; bad for the patient, expensive and inefficient for the system, but profitable for the individuals and agencies concerned.

133. Miss Christine Hancock of the RCN described succinctly to us the historic basis of the bank nursing system which was established to:

> "enable people, particularly people returning with family commitments who were not able to make a regular commitment to a number of hours, to work on a casual basis when it suited them. It enabled the Health Service and usually the hospitals to have a pool of people that they could call on in peak times. It was never designed as a way of either using overtime or of running your main staffing."[160]

In her view the bank system has been "grossly abused" forcing nurses to work for agencies rather than being exploited under the bank system.[161]

134. We recognise that in areas where there are substantial staffing shortages, agency and bank staff are at present a necessity.[162] We also accept that there will always be a role for agency staff in the NHS, for example to provide cover for maternity or other leave. But we would like to see an immediate reduction in the use of agency staff. We believe that employing agency staff on a more or less continuous basis to prop up an organisation sagging from personnel shortages is no solution to the problem. We share the belief of Ms Jocelyn Prudence of PAMs that:

> "It must be cheaper to the Government to invest in retention solutions to just stem the flow of staff from the NHS."[163]

135. The payment of appropriate overtime rates should amount to a simple and effective way to allow proper financial reward when extra hours have to be worked. It would also create additional commitment to a regular team and improve patient care. Accordingly, **we recommend that overtime payments should replace undue reliance on agencies as soon as possible. Moreover, the bank system should not be used as a method of cheap labour but should instead be used as a useful flexible working practice to cover unexpected shortages.**

Continuing Professional Development (CPD)

136. The memorandum from DoH recognised the need for a "culture that values lifelong learning."[164] It also referred to high quality services being underpinned by continuing personal development.[165] Currently there does not seem to be agreement between theory and practice in this regard; the responsibility for keeping up with developments in patient care appears to rest solely with staff. For example, the Royal College of Nursing said "Nurses frequently have to fund their own CPD activity and participate in their free time."[166] PAMs described "very little support for continuing personal development."[167] The Conference of Clinical Scientists' Organisation bemoaned a lack of funding for such development,[168] whilst Macmillan Cancer Relief suggested there was a lack of opportunity[169] for it.

137. In Darlington we heard that, in circumstances where funding for courses was available, time was not. Even cover for maternity leave causes major difficulties. A paediatrician in Darlington told us that, historically, doctors had been given protected time and money for continuous learning, which is why they were treated differently. He believed that the NHS needed to encourage CPD

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[160] Q161.
[161] Ibid.
[162] Q165.
[163] Q163.
[164] Ev. p6, para 4.11.
[165] Ibid, para 4.14.
[166] Ev. p100.
[167] Ev. p74.
[168] Appendix 16.
[169] Appendix 77.

for other staff. Miss Louise Silverton of the RCM told us there were 60,000 midwives on the register but not practising.[170] It was hard to see how they could be encouraged to return if they had to pay for a return to practice course.

138. The Government's Consultation Paper *A First Class Service* points out that currently "Most health professionals share financial responsibility for their own professional development."[171] We have made reference in our report to the extraordinary pace of change in healthcare technology and the consequent impact on patterns of care. A corollary of this is the need to keep staff in touch, so far as possible, with the most modern techniques. The pressure to continue learning is stressful, particularly when the well-being of others depends on the skills involved. Study requires finance, time and effort. Staff in the NHS often have to put in the time and effort on top of their daily work routines. We believe that they should not have to pay for the necessary courses out of their own salaries. **We recommend that the NHS finances in full the relevant professional educational needs of its staff. We also believe that current study arrangements are inadequate and need to be extended.**

139. Acceptance of this recommendation would, of course, increase the cost of running the Service, both in terms of the provision and the need to introduce cover for those on study-leave. But we believe the benefits to patients, staff and the NHS of a more efficient and motivated staff would far outweigh the financial investment. We also believe that such an initiative would encourage those who have left the service to return, and that this would result in value for money savings when set against the cost of recruiting new staff or employing staff from agencies. The knowledge that professional skills were nurtured in the NHS would increase its allure to potential employees.

Private Finance Initiative

140. The Private Finance Initiative was introduced during the Autumn Statement of 1992. The aim was: "to find new ways of mobilising the private sector to meet needs which have only been met by the public sector."[172]Most of the current wave of capital investment in the NHS hospital sector is funded through PFI. The larger NHS PFI schemes[173] are all based on 'design, build, finance and operate' contracts under which NHS trusts receive the use of privately financed facilities and their associated services in return for a series of payments over the contract period. The capital for the investment is raised by the private sector and is repaid through the payments received from the NHS trusts. Eleven contracts have so far been signed for developments in England and Wales.

141. When we visited Birmingham we were told of the dissatisfaction felt by staff as a result of what they described as a management policy of adopting PFI proposals at any cost. There was a general perception that PFI and contracting-out created a situation giving primacy to profit rather than service. It was argued that the NHS ethos of teamwork would ultimately be eroded by the proposed PFI developments.

142. The NHS Confederation argued that PFI was equally unpopular with managers:

> "We do not want to have demoralised, demotivated staff who are unhappy to work for us...the PFI process...is at best a hindrance to the way we plan our capital developments. PFI is slow, it is bureaucratic, it requires us to put up a vast amount of management time and consultancy fees at risk without the certainty of success. The schemes are not...necessarily better value for money...or, they achieve that by reducing the terms of working conditions of the staff involved. There is an element of profit in PFI, which is necessarily taken by the private sector to motivate them to go into it in the first place, which results in an element of bad value for the NHS...At ground level [PFI] is a very damaging development in terms of staff morale and inter-disciplinary working."[174]

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[170] Q174.
[171] Para 3.38, p45.
[172] Autumn Statement, 18 November 1992.
[173] In this context "larger" is defined as costing more than £25-30 million.
[174] Q282.

143. The Director of Human Resources at NHSE told us that the Government would expect employers who took over as a result of PFI to adhere to terms similar to those previously provided.[175] Trusts would be required to enquire into the employment practices of the organisation as well as its proposed staffing policies.[176] The Government also wanted unions to let trusts have an assessment of the employers concerned.[177] The Director of Human Resources admitted that there was as yet no system of monitoring employment practices, but expected this would be given attention as PFI developed.[178]

144. In supplementary written evidence the BMA indicated its concern about the impact of PFI on the NHS. It said:

> "The BMA...is of the view that it is not an affordable long term strategy for increasing capital investment in the health service."[179]

145. Serving private capital investment carries a premium when compared with the standard capital charges levied for public sector capital investment. The question which needs to be asked – now informed by published business cases for PFI schemes – is where this premium is to be found. Given that the largest element of NHS expenditure relates to staff costs, one conclusion might be that PFI schemes are based on an assumption that a level output of services can be achieved with reduced staff costs whilst maintaining good employment practices. We have not seen evidence to support this assumption. However, healthcare delivery and its funding are dynamic in nature. It is conceivable that new facilities will lead to efficiencies in the use of staff but this cannot be guaranteed in advance. In the short term reductions in staff numbers would seem to staff themselves to be the immediate impact of the introduction of PFI schemes. We believe that further exploration of the impact of PFIs is required before significant levels of recurrent NHS funds are devoted to the servicing of the private capital involved.

146. An argument raised in favour of the PFI schemes is that non-clinical staff can be more effectively managed than is currently the case. This has been challenged on two counts. First, the division between clinical and non-clinical staff is artificial. Hospitals function best through integration of work of many different staff groups. Porters and cleaners as well as nurses and doctors need to understand the primacy of patient care in everything they do. A division in the management of clinical and non-clinical staff is unlikely to be conducive to high quality services to patients. We heard anecdotal evidence supporting this argument. Second, we have heard evidence from the unions representing both clinical and non-clinical staff challenging the assumption that dividing the management of these two groups does not achieve greater value for money. We are aware that in many cases headline cost savings from contracting out for non-clinical services appear to have been associated with deterioration in the conditions of work for the staff involved and with a consequential negative effect on staff morale.[180]

147. In oral evidence Mr Roger Kline of MSF declared:

> "the jury has already decided that there are no benefits to patients from PFI and I think the onus is on the Department to demonstrate that the so-called financial benefits somehow compensate for what are demonstrable losses in team working and patient care."[181]

148. To say that there is no benefit to patients is probably an exaggeration, at least in the short term. The attraction of new facilities and state of the art provision to replace dilapidated premises and obsolete equipment, along with a means to supply them, can hardly be denied. The secrecy surrounding the PFI business plans and the resultant confusion has not helped persuade opponents of the schemes that there might be advantages albeit with certain modifications.

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[175] Q58
[176] Ibid
[177] Ibid
[178] Q59.
[179] Ev. p156.
[180] For differing views on the PFI schemes see the supplementary written evidence from DoH - Appendix 1 and a group of academic experts - Appendices 52 and 53.
[181] Q194. See also Q189.

149. UNISON believed that inherent in the PFI schemes was the notion that staff were more efficiently managed in the private sector, but claimed that there was no evidence for this supposition.[182] At the moment staff described as non-clinical become eligible for transfer through PFI or compulsory competitive tendering. It was put to us that the clinical/non-clinical division would increase professional barriers. It was also argued that the distinction was often arbitrary and difficult to define.[183] Dr Bogle of the BMA agreed:

> "How do you actually draw the line? What does clinical mean?[184]

150. Miss Christine Hancock thought that the NHS needed to be more clear about what its core business is before it transfers to a separate employer ancillary staff who work close to patients. She said:

> "It seems to me a lot of what people call unclinical services are core businesses."[185]

Miss Hancock also expressed concern about the reduction in nursing staff based on the loss of beds inherent in the PFI schemes.[186]

151. The memorandum from UNISON called for the NHS to:

> "Abandon the use of market testing/contracting out and end the transfer of staff to the private sector under the PFI."[187]

and informed us that:

> "New forms of PFI have been suggested and piloted which exclude staff so this could be done without abandoning PFI completely."[188]

152. PFI schemes are likely to have an impact on most of our inquiries and we intend to keep a careful and critical eye on a strategy that involves considerable public cost but whose advantages remain unproven. At the moment we remain agnostic about the long-term benefits of PFI. We do though regret the transfer of ancillary staff to the private sector that is currently a consequence of PFI. **The often spurious division of staff into clinical or non-clinical groups can create an institutional apartheid which might be detrimental to staff morale and to patients. We believe the Government should limit PFI to a number of pilot schemes until a proper evaluation of the impact on staff and patient care is produced.**

Pay

153. In its written evidence to us the Government rejected the view that pay was the sole issue in NHS recruitment and retention.[189] It argued that "the pay of health professionals over the last few years has grown ahead of average earnings."[190] Current assessments of average earnings were provided, along with the comment that:

> "Over the last few years nurses' earnings have risen at a faster rate than the average for the economy, 3.2 per cent ahead of earnings elsewhere in the economy and exceeding a 17.6 per cent rate of inflation."[191]

154. The RCN believed that poor pay and poor career prospects prolong shortages[192] and PAMs

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[182] Q189.
[183] Q192.
[184] Q194.
[185] Q197.
[186] Ibid. See also Q199 and Appendix 53.
[187] Ev. p105, para 37.
[188] Ibid.
[189] Ev. p5, para 4.3.
[190] Ibid.
[191] Ibid.
[192] Ev. p91.

thought a pay increase would help low morale.[193] Mr Roger Kline of MSF suggested that unless "they can get their heads around pay...and that means a new pay system"[194] a question mark would remain over the Government's human resources strategy:

> " whilst pay is not the only issue it is a central one...."if you do not employ [staff] in the right numbers and with the right training it actually costs the Health Service lots and lots of money."[195]

155. Mr Abberley of UNISON told us:

> "the Government has to stop seeing putting money into staff as not putting money into patient care; putting money into staff is putting money into patient care; it is the same thing."[196]

This lesson has been learnt. On 23 September 1998 the then Minister of State at the DoH launched a £50 million package to tackle nurse shortages. He said

> "We will not succeed in modernising the services the NHS provides unless we also modernise employment practice in the NHS. The health service is already the country's biggest employer. It should be our best employer too. The message we have to hammer home again and again is that quality of care for staff and for patients go hand in hand."[197]

156. Justifiable concern was voiced over the worsening pay differentials for staff outside the remit of the pay review bodies[198] and the fact that currently those bodies were not required to consider or cross-reference each others' work[199] We were told by one witness that changing the pay system without the provision of adequate resources would be difficult.[200]

157. We have commented favourably on the Government's plans to reform the NHS, including their desire to secure a quality workforce. We note they are broadly welcomed by staff. The one obstacle to their swift and successful implementation was the inadequate and unrealistic levels of pay in the NHS. New buildings, improved management and high ideals would bear no fruit if incomes were too low to attract the numbers and quality of staff necessary to reduce undue workloads, diminish the consequent stress, and thereby improve patient care.

158. On 1 February the Government accepted the 1999 pay review bodies' recommendation of an above inflation pay award for all staff in the NHS amounting to a minimum 4.7 per cent for nurses, midwives, health visitors and PAMs and 3.5 per cent for doctors and dentists.[201] The starting pay for newly qualified nurses was increased by 12 per cent, a level that should help in the recruitment drive. It remains open to question whether the increased rates for other staff are sufficient to improve morale and to attract people back to the profession. We see this as the first step towards the Government showing commitment to staff and we welcome its stated intention to modernise the NHS pay system.[202]

159. The pay award for hospital ancillary workers has yet to be announced. In reaching its decision on this group of essential NHS staff we trust the Government will bear in mind the contribution they make towards patient care in the context of a unified team and the particularly low level of pay that many of these staff experience. We look forward to a generous settlement.

160. A new pay system is now necessary. The current method is unpopular and open to abuse by managers. In Darlington a radiographer expressed concern at the tension caused by 60 per cent

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[193] Ev. p75.
[194] Q214.
[195] Ibid.
[196] Q143.
[197] DoH Press Release, No. 98/396, 23 September 1998.
[198] Q214.
[199] Q208.
[200] Q209.
[201] Official Report, 1 February 1999, cols 524-526w.
[202] Ibid, col 526.

of staff in her trust being employed on less favourable trust terms whilst the remaining 40 per cent were employed on Whitley terms. In Birmingham we were told that the present pay determination system was divisive and pitted one set of staff against another. The NHS Confederation believed that at present there was no "consistency of approach and evaluation between the various different professions"[203] and would welcome a new pay system which addressed the problem.[204] Acknowledging the complexities involved and the need for more work, **we recommend that the time has come for the NHS to move towards a single pay spine for all personnel. Terms and conditions should be negotiated nationally.**

161. In our view the development of the pay spine should have several components. It should demonstrate to the workforce equity and openness in the employment of staff; encourage trusts to be clear about local skill mix requirements, encourage shared learning, especially across relevant staff groups and encourage flexible education programmes.

The Pay Review Bodies

162. There are currently two pay review bodies, one for doctors and dentists and one for nurses, midwives, health visitors and PAMs. They were established in 1983 with a view to avoiding recurrent disputes between the professions and the health departments, ensuring fair levels of remuneration and safeguarding the interests of the taxpayer. Members of the bodies are drawn from a variety of different fields. They are appointed by the Prime Minister.

163. The review bodies report in January, allowing time for the Government to announce its decision on remuneration before employers prepare their budgets in the Spring. Recommendations are generally accepted, but there have been some exceptions. In 1993 the bodies did not report following the Government's decision to impose a 1.5 per cent pay rise on the public sector. In 1989 and 1990 some of the specific recommendations relating to doctors and dentists were rejected. Over recent years Government's have accepted the recommendations of the bodies but have staged the ensuing pay award.

164. The pay review bodies are required to take account of four key considerations: the need to recruit, retain and motivate staff, the health departments' output targets for the delivery of services, the funds available to the health departments and the Government's inflation target. They are also asked to consider economic and other evidence submitted by the Government, staff and the professions.

165. We think it is time now to reorganise the pay review body system in order to inculcate a greater sense of team spirit within the NHS. **We therefore recommend its replacement with the establishment of a single body charged with the task of reviewing the pay of all NHS professionals. This body should have within its remit all NHS staff, for example, clinical scientists and ancillary workers, who are not included in the current pay review bodies. The independence of the body should be secure and unassailable.**

Conclusion

166. The Government is on the right track for revitalising the NHS. But it needs to recalculate the numbers necessary to overcome staff shortages and carry out the proposed reforms. It should provide proper resources for the continuous learning process that modern health care demands. It should be extremely cautious in negotiations concerning the private finance initiative. Above all it should continue to provide salaries for NHS staff that are commensurate with the responsibilities involved.

167. The recommendations we have made in this report will cost significant amounts of public money. We are confident that the people of this country will support our conclusions and will be prepared to see them financed. Providing sufficient funds for the NHS and its staff under the banner of the pursuit of quality healthcare is an investment in the future.

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[203] Q263.
[204] Ibid.

Summary of Recommendations

168. (a). We recommend that the Government takes steps to introduce stronger formal links between the National Advisory Group for Scientists and Technicians (NAGST) and national professional bodies. (paragraph 31).

(b). We consider that with immediate effect there should be improved interaction between the medical and non-medical planning bodies. (paragraph 34).

(c). We believe that there should be regular meetings between MWSAC and REDGs, who should exchange information, discuss new ideas and develop plans. (paragraph 35).

(d). We recommend a major review of current planning procedures which should pay particular regard to their rationalisation and eventual replacement by an integrated planning system. We think it necessary that any new system should not only incorporate the national overview currently provided by the sub-group of the NHSE, but also actively promote a national strategy for workforce planning which, allowing for local conditions, brings a sense of consistency and cohesion at present notable for its absence. (paragraph 36).

(e). The issue of the provision of appropriate joint training throughout the UK should feature largely in the major review of current planning procedures that we have recommended. (paragraph 38).

(f). We suggest that DoH should ask the MWSAC to look in more detail at the balance between specialist and generalist training for doctors in achieving a flexible medical workforce. (paragraph 39).

(g). We recommend that efforts are made to co- ordinate local initiatives and assess their strategic impact on the future workforce numbers. We further recommend that co-ordinated pilot studies are undertaken to assess the impact of altering the skill mix. (paragraph 47).

(h). We recommend that the proposed number of medical students be increased by a minimum of 1,000 per year. This increase should be accompanied by a commensurate expansion in the number of senior doctors and consultants in order to provide for the necessary career opportunities and supervisory roles. (paragraph 59).

(i). The evidence we have received leads us to conclude that on current trends the projected increases in the number of nurses and other clinical staff fall well short of what is required to deal with current shortages and future developments in the NHS. We hope that recent Government initiatives will reverse these trends, but we suggest that the Government urgently reassesses its staffing figures to ensure an NHS workforce that is sufficient for requirements. (paragraph 64).

(j). We recommend that the Government consults with NHS employers and staff representative groups in order to establish a rigorous but fair system of efficiency appraisal. (paragraph 68).

(k). It seems to us that the introduction of formal exit interviews would help workforce planning by providing a better sense of the reasons why staff leave the NHS. We also recommend that DoH initiate a formal consultation on standardisation of information as soon as possible. (paragraph 79).

(l). Since the NHS will rely on overseas staff for many years to come, it is important that the Service ensures their career opportunities are not being restricted by their immigration status. We recommend that DoH consults with the Home Office and the Department for Education and Employment on these issues. (paragraph 83).

(m). We urge the Government to collate information from trusts in order to allow them to formulate a specific recruitment and retention strategy for pharmacists, scientists and all of the Professions Allied to Medicine as soon as possible. (paragraph 93).

(n). We would encourage education consortia, universities and the NHS to collaborate to ensure

that the opportunity exists for student nurses to experience clinical practice in a safe and supervised environment as early in the training programme as possible. (paragraph 111).

(o). We recommend that healthcare assistants working with nurses should be called "Assistant Nurses" and be registered with the UKCC. Healthcare assistants working with other professional groups should also be registered appropriately. Registration in such circumstances would provide professional motivation for the individual and would act as a necessary safeguard for the public who could then be assured that at all times care was being delivered by people whose competence was known and recognised. (paragraph 116).

(p). We recommend that every member of the NHS staff alone on duty in the community or otherwise at risk should have access to a mobile telephone or other means of establishing emergency contact with colleagues. (paragraph 128).

(q). We recommend that overtime payments should replace undue reliance on agencies as soon as possible. Moreover, the bank system should not be used as a method of cheap labour but should instead be used as a useful flexible working practice to cover unexpected shortages. (paragraph 135).

(r). We recommend that the NHS finances in full the relevant professional educational needs of its staff. We also believe that current study arrangements are inadequate and need to be extended. (paragraph 138).

(s). We regret the transfer of ancillary staff to the private sector that is currently a consequence of PFI. The often spurious division of staff into clinical or non-clinical groups can create an institutional apartheid which might be detrimental to staff morale and to patients. We believe the Government should limit PFI to a number of pilot schemes until a proper evaluation of the impact on staff and patient care is produced. (paragraph 152).

(t). We recommend that the time has come for the NHS to move towards a single pay spine for all personnel. Terms and conditions should be negotiated nationally. (paragraph 160).

(u). We think it is time now to reorganise the pay review body system in order to inculcate a greater sense of team spirit within the NHS. We therefore recommend its replacement with the establishment of a single body charged with the task of reviewing the pay of all NHS professionals. This body should have within its remit all NHS staff, for example, clinical scientists and ancillary workers, who are not included in the current pay review bodies. The independence of the body should be secure and unassailable. (paragraph 158).

MINUTES OF PROCEEDINGS RELATING TO THE REPORT

Thursday 11 February 1999

Members present:

Mr David Hinchliffe, in the Chair

Mr John Austin
Dr Peter Brand
Julia Drown
Mr John Gunnell
Dr Howard Stoate
Mr Robert Walter
Audrey Wise

The Committee deliberated.

Draft Report [Future NHS Staffing Requirements], proposed by the Chairman, brought up and read.

Ordered, That the draft report be read a second time, paragraph by paragraph.

Paragraphs 1 to 168 read and agreed to.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Several papers were ordered to be appended to the Minutes of Evidence.

Ordered, That the provisions of Standing Order No. 134 (Select Committees (reports)) be applied to the Report.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House. *(The Chairman.)*

[Adjourned till Thursday 25 February at Ten o'clock.

LIST OF ABBREVIATIONS USED IN THE REPORT

BMA	British Medical Association
CDNA	Community and District Nursing Association
CPD	Continuing Professional Development
CSR	Comprehensive Spending Review
DoH	Department of Health
LMWAG	Local Medical Workforce Advisory Group
MSF	Manufacturing, Science and Finance Union
MWSAC	Medical Workforce Standing Advisory Committee
NAGST	National Advisory Groups for Scientists and Technicians
NHSE	National Health Service Executive
NVQ	National Vocational Qualification
PAMs	Professions Allied to Medicine
PCG	Primary Care Group
PFI	Private Finance Initiative
PWR	Pay and Workforce Research
RCM	Royal College of Midwives
RCN	Royal College of Nursing
REDG	Regional Education and Development Group
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

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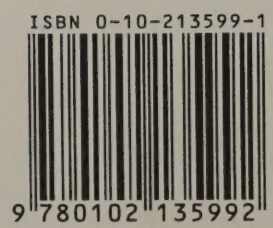

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